TN OCULOPLASTICS

CONTACT/DEMOGRAPHIC/PATIENT INFORMATION:

PATIENT NAME: _____
LAST FIRST MIDDLE

SSN#: _____-_____-_____ **DATE OF BIRTH:** _____/_____/_____ **AGE:** _____ **SEX:** **M** **F**

PATIENT ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME (_____) _____ CELL (_____) _____ **WORK** (_____) _____

WE MAY CONTACT YOU AND/OR LEAVE A MESSAGE AT? (Circle all that apply): **HOME** **CELL** **WORK**

EMAIL ADDRESS: _____ **OCCUPATION:** _____

CAN WE COMMUNICATE TO YOU BY: **Email** ____ **Yes** ____**No** **OR** **Text** ____**Yes** ____**No**

MARITAL STATUS: (Circle one) **SINGLE** **MARRIED** **WIDOWED** **DIVORCED**

RACE: _____ **ETHNICITY:** _____ **PREFERRED LANGUAGE:** _____

WHO REFERRED YOU TO OUR OFFICE? _____**PHONE:** _____

Address: _____
STREET CITY STATE ZIP

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____**PHONE** (_____) _____

Address: _____
STREET CITY STATE ZIP

_____
EMERGENCY CONTACT NAME **RELATIONSHIP** **PHONE NUMBER**

IF THE PATIENT IS UNDER 18, WHO IS RESPONSIBLE FOR THE ACCOUNT?

_____
NAME RELATION DOB SSN#

Skilled Nursing Facility/ Nursing Home/ Long-Term Care Facility Info

Is patient in SNF or LTC facility? (*Circle one*) YES or NO **Does the patient have a Power of Attorney? (*Circle one*) Yes or No**

Name/Contact of Facility: _____

TN OCULOPLASTICS

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

PLEASE LIST FAMILY MEMBER(S) OR PERSON(S) WHERE WE ARE ABLE TO SHARE YOUR MEDICAL RECORD / PATIENT INFORMATION:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION: *(COPY OF INSURANCE CARD IS REQUIRED)*

PRIMARY INSURANCE COMPANY:

INSURANCE NAME: _____

NAME OF POLICY HOLDER: _____
LAST FIRST MIDDLE

POLICY HOLDER DATE OF BIRTH: _____/_____/_____ **POLICY HOLDER SS#:** _____-_____-_____

POLICY HOLDER EMPLOYER OR COMPANY NAME: _____

SUBSCRIBER/ MEMBER ID # _____ **GROUP #** _____

SECONDARY INSURANCE COMPANY:

INSURANCE NAME: _____

NAME OF POLICY HOLDER: _____
LAST FIRST MIDDLE

POLICY HOLDER DATE OF BIRTH: _____/_____/_____ **POLICY HOLDER SS#:** _____-_____-_____

POLICY HOLDER EMPLOYER OR COMPANY NAME: _____

SUBSCRIBER/ MEMBER ID # _____ **GROUP #** _____

SIGNATURE: _____ **Date:** _____